DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES	. 1		PRINTED:	09/20/201
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	45	11/02/12	FORM	<b>APPROVE</b> (
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	
		445422	B. WING		004	70040
NAME OF F	PROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 09/1	<u>7/2012</u>
ETOWAI	HEALTH CARE CEN		4	09 GRADY ROAD, PO BOX 957 TOWAH, TN 37331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(XS) COMPLETION DATE
K 025 SS≂D	Smoke barriers are least a one half hou accordance with 8.3 terminate at an atric protected by fire-rat panels and steel fra separate compartm floor. Dampers are penetrations of smo	ke barriers in fully ducted and air conditioning systems	K 025	DISCLAIMER: "Preparation and execution of this plan of correction constitute admission or agreement provider of the truth of the facts a conclusions set forth of the statem deficiencies. This plan is prepared executed solely because it is required.  Administrator D	n does not t by the lleged or ent of and/or red."	10/23/12
SS=D	Sased on observation smoke barrier fire rather findings included Observation on Sepa.m. revealed nume (1) hour construction housekeeping storagarea.  This finding was versupervisor and acknowledge administrator during September 17, 2012 NFPA 101 LIFE SAFElectrical wiring and	tember 17, 2012 at 10:20 rous penetrations in the one in that separates the ge room from the patient care diffed by the maintenance owledged by the the exit conference on	K 147	What corrective action(s) will be a for those residents found to have be by the deficient practice?  No residents could be identified. Per the (1) hour construction that separate housekeeping storage room from the area was caulked by maintenance asseptember 17, 2012.  How will you identify other resident the potential to be affected by the sedeficient practice and what correct will be taken.  Maintenance staff was instructed on administrator as to the need for insperated walls to prevent penetration from without immediately correcting upon observation. Maintenance director in building to identify other penetration were found.	netrations in tes the patient care sistant on here action where action 19/17/2012 by extion of fire on occurring the patient care of the patient care sistant on 19/17/2012 by extion of fire on occurring the patient occur	
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	TUDE			
	> often	Medical resembling Signa	NUKE	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MV9321

Facility ID: TN5405

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

AND FLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDII	NG 01 - MAIN BUILDING 01	COMPLE	:TED	
		445422	B. WING		09/17/2012		
NAME OF PROVIDER OR SUPPLIER  ETOWAH HEALTH CARE CENTER			REET ADDRESS, CITY, STATE, ZIP COD 109 GRADY ROAD, PO BOX 957 ETOWAH, TN 37331		172012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 147 SS=D	Smoke barriers are least a one half ho accordance with 8 terminate at an attracted by fire-rapanels and steel from separate compartration. Dampers are penetrations of smith heating, ventilating 19.3.7.3, 19.3.7.5,  This STANDARD Based on observation on Seased on observation on Seasmoke barrier fire in the findings included to the season of the season	is not met as evidenced by: tion, the facility failed to assure ratings are maintained. e: ptember 17, 2012 at 10:20 erous penetrations in the one on that separates the age room from the patient care entitled by the maintenance nowledged by the of the exit conference on	K 025	Facility areas including locked sto be inspected monthly by maintena or designee for penetrations and replaced on the monthly preventativ log.  How the corrective action(s) will to ensure the deficient practice vi.e., what quality assurance progput into place:  It will be the responsibility of the Director to review monthly logs, to minimum of four weeks or until second in the compliance is achieved. Findings monthly logs will be reviewed by director to determine any trends, periodem areas and will be discussed. Quality Assurance (QA) meeting a action plan will be developed and necessary.	to ensure that ecur: rage areas will nee department esults will be emaintenance be monitored will not recur, ram will be Maintenance imes a abstantial from the maintenance atterns and or ed in the next and a corrective implemented if	10/23/12	
/	C. Stor C	<u> </u>	IURE	TITLE		(X6) DATE	
	EMMI- C	<u>- 7 (5 </u>		CNHA	70	1/1/1	

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If continuation sheet Page 1 of 2

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445422		445422	B. WING		09/17/2012	
NAME OF PROVIDER OR SUPPLIER  ETOWAH HEALTH CARE CENTER				TREET ADDRESS, CITY, STATE, ZIP CODE 409 GRADY ROAD, PO BOX 957 ETOWAH, TN 37331	00,11120.2	
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION	
K 025 SS=D	Smoke barriers are least a one half hot accordance with 8. terminate at an atri protected by fire-ra panels and steel fra separate compartm floor. Dampers are penetrations of smo	FETY CODE STANDARD  constructed to provide at ur fire resistance rating in 3. Smoke barriers may um wall. Windows are ted glazing or by wired glass ames. A minimum of two nents are provided on each not required in duct oke barriers in fully ducted and air conditioning systems. 19.1.6.3, 19.1.6.4	K 02			
•	Based on observation on Separation on Separa	s not met as evidenced by: tion, the facility failed to assure atings are maintained. e: otember 17, 2012 at 10:20 erous penetrations in the one on that separates the age room from the patient care	-			
K 147 SS=D	supervisor and acking administrator during September 17, 201: NFPA 101 LIFE SAI Electrical wiring and with NFPA 70, National Supervisor (NFPA 70, National S	the exit conference on 2. FETY CODE STANDARD dequipment is in accordance onal Electrical Code. 9.1.2	K 147	Any findings from contracted installati reviewed by maintenance director to decompliance. If any problems are identified discussed in the next Quality Assuranceting.	ions will be etermine iffied it will ance (QA)	
LABUKA <u>TORY</u>	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN.	ATURE	TITLE	(X6) DATE	
	anne (c	VIJ		CNHIA	147/19-	

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		445422	B. WING_		09/	17/2012
1	ROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODE 409 GRADY ROAD, PO BOX 957 ETOWAH, TN 37331	1 00,	1012012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 025 SS≃D	Smoke barriers are least a one half hot accordance with 8. terminate at an atri protected by fire-ra panels and steel fra separate compartm floor. Dampers are penetrations of smo	e constructed to provide at ur fire resistance rating in 3. Smoke barriers may um wall. Windows are ted glazing or by wired glass ames. A minimum of two nents are provided on each not required in duct oke barriers in fully ducted and air conditioning systems. 19.1.6.3, 19.1.6.4	K 025			
	Based on observar smoke barrier fire r The findings include Observation on Sepa.m. revealed nume (1) hour construction	s not met as evidenced by: tion, the facility failed to assure atings are maintained. e: otember 17, 2012 at 10:20 erous penetrations in the one on that separates the age room from the patient care				
K 147 SS=D	supervisor and ack administrator during September 17, 201 NFPA 101 LIFE SA Electrical wiring and	the exit conference on	K 147	DISCLAIMER: "Preparation and execution of this plan of correction constitute admission or agreement provider of the truth of the facts all conclusions set forth of the statemedeficiencies. This plan is prepared executed solely because it is require	does not by the leged or nt of and/or ed."	10/25/12
AROBATOR	( DISECTORIO CO DE CO		<del></del>	Administrator	Date	
LABOKAT <u>DRY</u>		ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE
	soft 5	×/2)		LNTA		K13/13-

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	445422		B. WING			09/17/2012	
NAME OF PROVIDER OR SUPPLIER  ETOWAH HEALTH CARE CENTER			•	40	EET ADDRESS, CITY, STATE, ZIP CODE 09 GRADY ROAD, PO BOX 957 TOWAH, TN 37331		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 147	This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure electrical wiring is installed in accordance with NFPA 70.  The findings include:  Observation on September 17, 2012 at 10:10 a.m. revealed one (1) orange electrical extension cord wired directly in to the electric panel with no conduit as permanent use for emergency power when needed.  This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on September 17, 2012.		K 147		K 147 LIFE SAFETY CODE STAN  What corrective action(s) will be act for those residents found to have be by the deficient practice?	complished	4/23/12
					No residents could be identified. The (1) orange electrical extension cord wired directly into the electric panel with no conduit as permanent use for emergency power when needed, was removed and was hard wired, to panel and wire was placed inside conduit and ran to a receptacle outlet with a red emergency face plate by licensed electrician.		
					How will you identify other resident the potential to be affected by the sadeficient practice and what corrects will be taken.  Maintenance was in-serviced by admit 9/17/2012 in regards to the installation voltage electrical wire, emergency or emergency, within building being run conduit. Maintenance staff inspected emergency wiring to identify if other in need of being placed in conduit. Na areas of concern were identified.	nistrator on n of line non- through other wires were	
					What measures will be put into place systemic changes you will make to a the deficient practice does not recurred to the deficient practice does not recurred to the consistency possessible will have wires ran in conclude the contract of the completion of the contracted electrical work, maintenant will inform contractor of the correct	wer is luit and ent or ding to of any ace director	

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		445422	B. WING			09/17/2012	
NAME OF PROVIDER OR SUPPLIER  ETOWAH HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 409 GRADY ROAD, PO BOX 957 ETOWAH, TN 37331				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETION DATE
K 147	Based on observate electrical wiring is NFPA 70.  The findings included the findings included the findings included a.m. revealed one cord wired directly conduit as perman when needed.  This finding was we supervisor and act	is not met as evidenced by: ation, the facility failed to assure installed in accordance with  de: eptember 17, 2012 at 10:10 (1) orange electrical extension in to the electric panel with no nent use for emergency power  erified by the maintenance knowledged by the ng the exit conference on	K 1	147	How the corrective action(s) will be to ensure the deficient practice will i.e., what quality assurance program put into place:  Any findings from contracted installar reviewed by maintenance director to compliance. If any problems are iden be discussed in the next Quality Assuranceting.	not recur, n will be tions will be letermine tified it will	- 1 ( C C   M

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